

Case Number:	CM15-0009682		
Date Assigned:	01/27/2015	Date of Injury:	10/05/2009
Decision Date:	03/23/2015	UR Denial Date:	01/05/2015
Priority:	Standard	Application Received:	01/16/2015

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to an expert reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. He/she has been in active clinical practice for more than five years and is currently working at least 24 hours a week in active practice. The expert reviewer was selected based on his/her clinical experience, education, background, and expertise in the same or similar specialties that evaluate and/or treat the medical condition and disputed items/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:

State(s) of Licensure: California

Certification(s)/Specialty: Physical Medicine & Rehabilitation

CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

The injured worker is a 60-year-old male who reported injury on 10/05/2009. The mechanism of injury was not provided. The diagnoses included other and unspecified disc disorder of the lumbar region. The injured worker underwent an MRI of the lumbar spine, which revealed at the level L3-4 there was a 1 mm to 2 mm posterior disc bulge effacing the ventral surface of the thecal sac resulting in mild bilateral neural foraminal narrowing in conjunction with facet hypertrophy; there was mild canal stenosis and the bilateral exiting nerve roots had compromise. The documentation of 10/25/2014 revealed the injured worker had a diagnosis of lumbar instability at L3-4 and facet arthropathy at L3-4. The injured worker had grade 1 spondylolisthesis at L3-4 with opening the disc space. There was no gross motion. Physical examination revealed 1 to 2+ lumbar paraspinous muscle spasms in the lumbosacral spine. There was tenderness to palpation of these muscles. There was decreased range of motion. The deep tendon reflexes were 2+. The motor strength was 5/5. The treatment plan included facet blocks to see if they can relief back pain. There was no Request for Authorization submitted for review.

IMR ISSUES, DECISIONS AND RATIONALES

The Final Determination was based on decisions for the disputed items/services set forth below:

Lumbar Facet Injection L3-L4 bilateral: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG, Low Back, facet joint diagnostic blocks (injections)

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Chapter, Facet joint diagnostic blocks (injections) Facet joint medial branch blocks (therapeutic injections), Facet joint pain signs and Symptoms.

Decision rationale: The American College of Occupational and Environmental Medicine Guidelines indicate that a facet neurotomy (Rhizotomy) should be performed only after appropriate investigation involving controlled differential dorsal ramus medial branch diagnostic blocks. As the American College of Occupational and Environmental Medicine does not address specific criteria for medial branch diagnostic blocks, secondary guidelines were sought. The Official Disability Guidelines indicate that a medial branch block is not recommended except as a diagnostic tool. Minimal evidence for treatment. the criteria for the use of diagnostic blocks include the clinical presentation should be consistent with facet joint pain which includes tenderness to palpation at the paravertebral area, a normal sensory examination, absence of radicular findings although pain may radiate below the knee, and a normal straight leg raise exam. There should be documentation of failure of conservative treatment including home exercise, physical therapy, and NSAIDS prior to the procedure for at least 4 to 6 weeks and no more than 2 facet joint levels should be injected in 1 session. The clinical documentation submitted for review failed to provide documentation of a normal sensory examination and straight leg raise. The dermatomes were not addressed nor was the straight leg raise. There was a lack of documentation of a failure of conservative care for at least 4-6 weeks prior to the requested intervention. The motor strength was 5/5. The deep tendon reflexes were 2+. However, failing the documentation of a normal straight leg raise examination and documentation of a failure of conservative treatment including home exercise, physical therapy and NSAIDs prior to the procedure for at least 4 to 6 weeks, this request would not be supported. Given the above, the request for lumbar facet injection L3-4 bilaterally is not medically necessary.